DISCRIMINATION IN THE TREATMENT OF TRANSGENDER AND GENDER NON-CONFORMING YOUTH

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A thesis submitted to Johns Hopkins University in conformity with the requirements for the degree of Masters of Bioethics

Baltimore, Maryland

August 2019

Abstract

The age requirement included in the World Professional Association of Transgender Health (WPATH) Standards of Care (SOC) for genital surgery presents an ethical challenge for adolescent patients. Adolescents with Gender Dysphoria who are seeking irreversible genital surgeries are put at risk through the withholding of this evidence-based treatment. Even the most fortunate patients with full parental, medical team, and financial support experience unethical systematic barriers to timely medical treatment, including limitations to patient and family autonomy, prohibitions on insurance coverage, and dismissal of the accepted practice of shared decision-making.

This thesis explores the ethical problems and harms that arise from the age requirement for genital surgery and lays out arguments that support the removal of the age requirement. Through a comparative analysis of medical decision-making for other adolescent populations, it is shown that no other types of adolescent medical decisions implement age restrictions to prohibit treatment when all parties agree that it is in the youth's best interest. This demonstrates a mistrust *solely* in the adolescent transgender community. Further, potential concerns for regret (i.e. sexual pleasure, fertility) are not supported by evidence and may be prevented with appropriate shared decision-making and counseling. Lastly, a description of the existing protections in place within the SOC show that the best interests of transgender and gender nonconforming adolescent patients can still be ensured without the barriers and harms imposed by the age requirement.

In conclusion, WPATH should remove the age requirement for irreversible genital surgery from the SOC because known harms (physical, psychological, social stigma and discrimination) outweigh theoretical benefits (avoiding regret). Not addressing this is discriminatory and

unethical. The proposed solutions are to remove the minimum age requirement for genital surgery and modify the existing language in the WPATH SOC to promote full autonomy and shared decision making between the adolescent patient, parents and multi-disciplinary medical team.

Primary Reader and Advisor: Dr. Rebecca Seltzer
Secondary Reader: Dr. Gail Geller

Acknowledgements

I would like to share my gratitude to my advisor, professor and mentor Dr. Becky Seltzer for being supportive of my passions from early on in my education at Johns Hopkins. Becky guided me to the inspiring physicians of Harriet Lane Gender Emerge Clinic where I was exposed first hand to the trials of the transgender adolescent patient. Dr. Seltzer is an inspiring pediatrician, child advocate, and educator and I am so thankful for the care, attention to detail and endless time she put into strengthening not only my thesis, but my advocacy skills.

I would also like to thank Dr. Gail Geller for her support throughout my thesis experience. Her unique perspective and astonishing intellect challenged my thesis to grow in ways I could have never imagined. I am so grateful for the opportunity to learn from her. Lastly, I would also like to acknowledge Dr. Travis Rieder for his unwavering and unconditional support. His wealth of knowledge and wonderful wit made every class better. I would like to thank him for always being available to listen and advise, even when he was in the middle of writing, publishing, and recording a new book. Lastly, I would like to thank all of the Berman Institute of Bioethics team, for a wonderful experience and education.

Dedications:

I would like to dedicate this thesis to my parents, Michelle and Jerry Docchio for their unconditional love and support, and to my cohort who turned into family, Margot, Emily, Hunter, Vivian and Christen.

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I. Introduction

There are an estimated 150,000 adolescents between the ages of 13 and 17 who identify as transgender in the United States.[1] Currently in America and across the world, transgender youth are a marginalized and at-risk population. Youth who identify as transgender or gender nonconforming (TGNC) remain at risk for comorbidities, such as mental health issues, stigmatization, discrimination, self-inflicted harm, violence and victimization.[2,3,4] Higher rates of post-traumatic stress disorder (PTSD), major depression, conduct disorder and suicidal ideation, planned or attempted, have been shown in transgender youth.[4]

It is important to note the differences and definitions between patients who are gender nonconforming and those who experience gender dysphoria (GD). GD refers to the discomfort or distress related to a person's gender assigned at birth (including physical anatomy and/or associated gender roles) not aligning with their gender identity.[5,6] The Institute of Medicine defines gender nonconformity as "the extent to which a person's gender identity, role, or expression differs from the cultural norms prescribed for people of a particular sex.[5] The World Professional Association of Transgender Health (WPATH) and its Board of Directors have made efforts to de-psychopathologize gender nonconformity by stating that "the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth, is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative."[6]

While only a subset of gender nonconforming people experience GD, for some patients with GD, the level of distress can be so significant that it meets formal diagnostic criteria for a mental health disorder.[4,6] GD can be alleviated in large part through treatment.[7] Treatment for

GD emphasizes an individualized approach, and "what alleviates GD for one person may not work for another."[6,8]

A. WPATH's Standard of Care

Currently, WPATH remains the leader of health care for persons who identify as transsexual, transgender, or gender nonconforming. WPATH was created to provide physicians with internationally accepted, evidence-based, ethical Standards of Care (SOC) for the treatment of individuals with GD. These internationally accepted guidelines are designed to promote the health and welfare of transgender, transsexual and gender variant persons in all cultural settings. The SOC are updated and revised as new scientific information becomes available.[9]

The WPATH SOC identifies three categories or stages of individualized medical treatment options available to adolescent patients exploring their gender identity.[6,10] The first stage includes fully reversible interventions, such as puberty blockers. GnRH analogues are given to suppress estrogen or testosterone production, consequently delaying the physical changes of puberty.[6] The second stage involves partially reversible interventions, including hormone therapy to masculinize or feminize the body. While some hormone-induced effects can be reversed (e.g. breast reconstruction for estrogen-induced gynecomastia), others are permanent (e.g. deepening of the voice by testosterone).[6] The third stage includes irreversible interventions, such as chest and genital surgery.[6]

For TGNC patients, gender affirming health care is a relatively new area of medicine that poses a host of bioethical issues for the medical community.[11] In this paper, I will specifically focus on the ethical concerns related to the systematic barriers to genital surgery for adolescent patients created by the WPATH SOC. I will argue that the age requirement for adolescents

seeking gender affirming genital surgery is unethical as it perpetuates harms and cultural biases against TGNC youth while hindering patient & family autonomy within the health care system.

B. Irreversible Surgeries: An Evidence-based Practice

Current WPATH SOC categorize genital surgery and chest surgery as irreversible interventions. WPATH highlights the value of such gender affirming surgeries as effective and medically necessary for the subset of patients within the TGNC community that experience ongoing GD.[6] While supporting such irreversible surgeries when medically necessary, WPATH does note that not all TGNC patients need this surgery as some find comfort within their own gender identity, roles and expression without seeking gender affirming surgery.[6,12] WPATH promotes the evidence-based practice of gender affirming surgery, citing follow-up studies that show beneficial postoperative outcomes including subjective well-being, cosmesis and sexual function.[6, 13-16]

Despite the value WPATH places on timely gender affirming surgery, it limits access for adolescent patients.[6] An adolescent patient seeking to alleviate GD by undergoing the third stage of treatment must first meet the following criteria as outlined by the WPATH SOC:

> "Genital surgery should not be carried out until (i) patients reach the legal age of majority to give consent for medical procedures in a given country, and (ii) patients have lived continuously for at least 12 months in the gender role that is congruent with their gender identity. The age threshold should be seen as a minimum criterion and not an indication in and of itself for active intervention."[6]

Therefore, an adolescent living in the U.S. cannot seek genital surgery until the age of 18, which is the age of majority in the U.S. Such age restrictions for genital surgery are directly in conflict with WPATH's assertion that the risks of irreversible surgeries for adolescents should not automatically outweigh the added risks of withholding treatment, stating "refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization."[6] Of note, when it comes to chest surgery, another gender affirming irreversible surgery, the specific age of majority requirement in the SOC criteria is not present. According to WPATH SOC:

> "Chest surgery in [patients transitioning from biologically born female to male] could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatment. The intent of this suggested sequence is to give adolescents sufficient opportunity to experience and socially adjust to a more masculine gender role, before undergoing irreversible surgery."[6]

I. The Problem

The age requirement included in the WPATH SOC for genital surgery presents an ethical challenge for adolescent patients. Adolescents with GD who are seeking irreversible genital surgeries are specifically put at risk through the withholding of this third stage treatment. Consider the fortunate adolescent patient that has full parental and financial support, has completed all three stages of treatment properly and effectively with full physician and psychiatric support, but is prohibited from completing their final transition until their 18th birthday. Therefore, even the most privileged patients (representing the minority of transgender youth) experience unethical systematic barriers to timely medical treatment, including limitations

to patient and family autonomy, prohibitions on insurance coverage, and dismissal of the accepted practice of shared decision-making.

There are no other types of adolescent medical treatment where age explicitly prohibits treatment when all parties are in agreement that it is in the youth's best interest. Additionally, the age requirement promotes harms related to withheld treatment such as social stigma, physical violence, psychological trauma and discrimination.[6] Therefore, WPATH should remove the age requirement for irreversible genital surgery from the SOC because known harms (physical, psychological, social stigma and discrimination) outweigh theoretical benefits (avoiding regret). Not addressing this is discriminatory and unethical.

A. The Issue of Autonomy in Minors

The ethical considerations surrounding adolescent autonomy in decision-making are particularly relevant in the world of TGNC gender affirming care, where the patient is most often the catalyst for medical intervention, seeking support from a multidisciplinary team of physicians and other professionals. Parents and medical professionals may feel uncomfortable with adolescents driving their own medical decisions, especially when that medical treatment involves an irreversible surgery. To temper this concern, there are extra protections put in place when contemplating the serious medical decisions of gender affirming care for the TGNC adolescent patient. TGNC adolescent patients seeking gender affirming care must receive explicit approval for treatment from a multidisciplinary team of physicians and professionals. This team usually includes pediatricians, endocrinologists, psychiatrists or psychologists, social workers and surgeons. All team members must be in communication and agreement with the proposed plan before further treatments (irreversible gender affirming surgeries) can occur.

The discomfort physicians and family alike may experience when exploring the complexities of gender affirming care for adolescent patients is not unexpected, as historically society and the medical community tend to be wary of leaving any major medical decision-making to the adolescent alone.[17-19] For most adolescent patients faced with a medical decision, determining what decision is in their best interest is guided by shared input from the patient, their parents/guardians and their physicians.[17] In today's society, children and adolescents under the age of 18 are generally unable to legally consent to their own medical care.[18] Autonomy in the medical setting requires both "liberty (independence from controlling influences) and agency (capacity for intentional action)."[18] It is generally agreed that minors are not completely autonomous, due to their limited capacity.[17-21,21-23]

However, there are several exceptions where minors are legally allowed to make their own medical decisions without the help of a parent or legal guardian. State-specific minor consent laws dictate situations where minors can consent to their own medical treatment/decisions. For example, in Maryland minors are authorized to consent for evaluation and treatment related to sexually transmitted diseases, birth control, substance use and emergency medical services.[23] According to a review conducted by the Guttmacher Institute, minors are allowed to seek mental health treatment in at least 20 states, and sexual reproductive services without parental support in all 50 states.[24] Additionally, minors may be allowed to consent to their own treatment if they are married, have a child, or are legally emancipated from their parents.[20-22,25]

The mature minor doctrine is another mechanism for minors to consent to or to refuse treatment for a medical condition. So long as the minor patient is found by a court to possess the maturity to understand the treatment in question, as well as the consequences, they should be able to make the decision to accept or reject treatment without parental agreement.[20] While states

have differing laws surrounding whether a medical professional or court is needed to invoke the mature minor doctrine, most states recognize that the patient must be at least 14 years of age.[20] The age of 14 comes from several empirical studies suggesting that a 14-year-old's decision-making ability is comparable to that of adults.[21] According to Douglas Diekema, the evaluation of capacity requires minors to both provide evidence and communicate a choice, understand relevant information and facts of the treatment, appreciate the situation and its consequences, and manipulate information in a rational way.[21] Further, the AMA Journal of Ethics requires the consideration of other competing interests, such as cultural and religious beliefs, expected treatment outcomes, likelihood of long-term survival and parent's consent.[17] The mature minor doctrine is most often found in the media when a minor patient refuses lifesaving care. Two examples where a court ruled in favor of the mature minor doctrine are the cases of 17-year-old Ernestine Gregory and 14-year-old Dennis Lindberg, both of whom refused blood transfusions for religious reasons.[21,24] Another prominent case was that of 16-year-old Starchild Abaraham Cherrix who refused chemotherapy for Hodgkin's disease, instead opting for an illegal alternative botanical treatment method known as Hoxsey.[26]

The mature minor doctrine exists in our court and medical system for the purpose of giving adolescents autonomy over their own health care when they reasonably do not agree with their physicians' and/or parents' recommended treatment plan. Therefore, there are legal allowances for adolescents as young as 14 to choose a treatment plan that may differ from what their physicians and parents think is in their best interest, even if it results in death. As is the case for patients like Lindberg, invoking the mature minor doctrine can permit adolescents to make medical decisions that result in their death, the most irreversible of outcomes.[21] So why is it that we allow patients as young as 14 to decide on medical treatments that have irrevocable

consequences, but not allow them to decide on professionally agreed upon evidenced-based TGNC treatments?

It is also important to note that the WPATH SOC are to be used internationally. The SOC's first eligibility criterion for irreversible surgeries is that "patients reach the legal age of majority in a given country."[6] Considering that the age of majority varies in different countries, we must question whether using age as a proxy marker for decision-making capacity has any legitimacy. For example, the National Health Service requires that UK patients 17 and older seeking care for GD be transferred and treated at an adult clinic where they can consent to their own gender affirming treatments.[27]

It is easy to rely on the idea that minors cannot legally consent to medical treatments before the age of 18. However, we have shown that this limitation does not apply to sexual health care, mental health care, emancipated minors, mature minors and minors in countries with a younger age of majority. These discrepancies highlight society's ability to flippantly place value on the age of 18. The legal system has made allowances for adolescent patients to exercise autonomy in their own medical care, which is still desperately needed for adolescent TGNC patients.

B. Barriers to Accessing Covered Care

The SOC are utilized not only by physicians, but also by insurance companies. There has been a recent push for non-discriminatory insurance coverage for transition-related services. In 2016, the U.S. Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR) revamped the original 2010 version of Section 1557 of the Affordable Care Act (ACA), releasing a detailed 362-page final ruling that explicitly prohibits discrimination based on gender identity in any health insurance policy.[28,29] While Section 1557 does not mandate the coverage of

gender related surgeries or treatment of GD specifically, some progressive insurance companies are beginning to adapt their plans based on the SOC. The Human Rights Campaign has created a comprehensive list of twenty-two insurance plans that will cover gender assignment surgeries, but stipulate that the individual must be at least 18 years of age, or "age appropriate" for the medically necessary surgery.[30] Of these referenced insurance plans, a majority reference the WPATH SOC specifically, including Aetna, Anthem BlueCross BlueShield, Cigna, and Health Net.[30-34] This shows that the WPATH SOC impacts not only patient-physician decision-making, but also a patient's ability to access covered care.

C. The Ethical Importance of Shared Decision Making

The placement of the age requirement in the SOC creates a systematic barrier to patient and family autonomy within the health care system. Refusing evidence-based medical treatment to patients and families on the basis of age alone ignores the American Medical Association's (AMA) Code of Medical Ethics, which encourages the practice of shared decision-making. While there is no universal definition of shared decision-making, the AMA Code of Medical Ethics describes a collaborative process where medical decisions about a minor are reached through discussion between patient (as cognitively appropriate), parents/guardians, and medical professionals.[17] The AMA Code of Medical Ethics most specifically addresses shared decision-making within the pediatric population by stating: "Decisions for pediatric patients should be based on the child's best interest, which is determined by weighing many factors, including effectiveness of appropriate medical therapies and the needs and interests of the patient and the family as the source of support and care for the patient."[17] While unemancipated minors are not routinely allowed to consent to medical decisions, with the exception of the examples in the

section above, they are routinely given the opportunity to provide assent and be involved in the shared decision-making process.[35]

While shared decision-making is a widely accepted and promoted model, it remains overridden in the case of adolescent TGNC patients by the WPATH SOC's age requirement, which prevents genital surgery in the US before age 18 even if all parties are in agreement that it is in the patient's best interest. The pertinent ethical issue created by the WPATH SOC's age requirement is the undermining of the accepted clinical practice of shared decision-making, even when the medical team, parents, and patient all agree on a decision. Not allowing TGNC patients and their guardians to utilize shared decision-making goes directly against the AMA's Code of Medical Ethics and does not support the best interest of the patient. In the next section, I will argue that prioritizing age over shared decision-making for TGNC patients and their families conveys a mistrust *solely* in the adolescent transgender community as well as their parents or guardians. I will provide examples of decision-making within other pediatric patient populations to highlight that the systematic withholding of shared decision-making is unique to patients seeking gender affirming care, which is both penalizing and discriminatory towards the TGNC community.

II. Comparing Shared Decision Making in other Adolescent Populations against the TGNC Adolescent Community

In the medical setting, physicians perform medically important interventions on children and adolescents fairly regularly. Using the term "important" is vital for this discussion, as irreversible surgeries may not be deemed "medically necessary" for all patients in all circumstances. However, for those seeking this form of gender affirming care to alleviate GD, the surgery is an

evidence-based practice that is medically important to relieve further suffering. As stated previously, by imposing the minimum age requirement for irreversible surgeries, WPATH does not allow parents to continue working with both the patient (their child) and medical team in the pursuit of their child's best interest. Indeed, I will suggest that the implementation of the minimum age requirement for irreversible surgeries endorses the predetermined discriminatory view that receiving irreversible genital surgery is solely a life choice rather than an evidence-based treatment for the complex medical consequences of GD. This is supported by the fact that both children and adolescent patients and their families seeking similar types of medical treatment and irreversible procedures have access to *and* are encouraged to utilize the shared decision-making model in order to determine treatment and timing of treatment that is in the best interest of the patient. The following examples highlight the inconsistency in the pediatric medical literature, and the unethical barrier TGNC patients face when seeking gender-affirming surgery.

A. Treatment for Mental Health

One example of medically important treatment routinely done in adolescent medicine is the treatment of mental illness, such as bipolar disorder, depression, or schizophrenia. While most treatments for mental illnesses are reversible, the contrast and commonalities surrounding the plight of TGNC patients in the areas of patient assent, shared decision-making, and the value the medical community places on treating mental health are worth noting. Typically, patients seeking medical intervention for mental illness have very similar experiences to patients seeking gender affirming care. Treatment varies based on the specific mental health diagnosis, but all treatment plans utilize shared decision-making between the treating physician and the patient's

family or legal guardians, taking into serious consideration patient assent. If a medication was deemed to be in the patient's best interest by both the physician and legal guardians, it would be unethical to withhold that medication from the child until they reached the age of 18. The importance the medical community places on treating mental illness in adolescents is evident in state laws that permit minors as young as 16 to consent to, *but not refuse*, physician recommended mental health treatment without parent/guardian consent.[36] Placing differences in reversibility aside, it remains that adolescent patients who seek medical intervention for mental illness are able to participate in shared decision-making with their physicians / guardians in pursuit of a happy and healthy life, while patients seeking gender affirming care are not given the same opportunity until they reach the age of 18.

B. Circumcision

It is fairly easy to support medically important and "necessary" interventions and surgeries on patients under the age of 18, so long as they are in the best interest of the patient's health. However, one should also recognize that medically "unnecessary" surgeries are performed on minors on a regular basis. And not just on any minors, but babies! In 2010, 58% of babies were circumcised at birth in the United States.[37] However, there is not a universal consensus on whether circumcision is always in the child's best interest. Proponents argue that the benefits of reduced risk of urinary tract infections, penile cancer and some sexually transmitted infections outweigh the risks, while opponents of circumcision argue that the procedure is not essential to the child's current well-being.[38,39]

In order to address this controversy, the American Academy of Pediatrics (AAP) conducted a research review, which led to the 2012 Circumcision Policy Statement. This statement reads as

follows; "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it."[38] The AAP advises physicians to remain unbiased and nonjudgmental when discussing this decision with parents.[38] The policy statement is significant because the AAP acknowledges that the surgery remains a choice for the families, and that only the parents are able to adequately weigh their own cultures, beliefs, and ethical reasoning against the health risks and benefits. This is an example where it is deemed appropriate for parents to make medical decisions about an elective and irreversible genital surgery for their child based on parent preference alone. And unlike the babies who have no say in this decision about their body, adolescent TGNC patients are informed about gender affirming surgery and are able to weigh the risks/benefits for themselves.

C. Cosmetic Surgery

Legally, parents are able to consent to several types of elective irreversible surgeries for minors. This is true for not only circumcision, but for cosmetic surgery as well. Cosmetic surgery could take the form of breast augmentation or rhinoplasty, to name only a few. According to the American Society of Plastic Surgeons (ASPS), parental consent is required for all plastic surgery procedures performed on teens younger than 18 years old.[40] However, what differs most from the case of TGNC patients seeking gender affirming surgery is that the ASPS places decision-making power of evaluating patient capacity explicitly in the hands of parents. The ASPS "advises parents to evaluate the teenager's physical and emotional maturity under the guidance of a plastic surgeon certified by The American Board of Plastic Surgery."[40] The same opportunity for parents to work with trained physicians to evaluate their child's capacity is not

provided for TGNC patients; rather, the SOC age requirement blocks all genital surgery before age 18.

The ASPS statement further stipulates that the most rewarding outcomes will result if "the teenager initiates the request, and the desire is clearly expressed and repeated over a period of time, the teenager has realistic goals, and the teenager has sufficient maturity."[40] Notably absent is the requirement for a psychiatric evaluation from a professional counselor, social worker or psychiatrist. In fact, the ASPS leaves this evaluation of emotional maturity and capacity for decision-making almost entirely up to the patient, their parents and their certified surgeon, without the additional "protections" (i.e. the age requirement, multiple professional psychiatric evaluations) that TGNC patients face when seeking gender affirming surgery.[40]

The various forms of cosmetic surgery come with varying degrees of risk, depending on the type of surgery, the patient's medical history, and the complexity of individual cases. The ASPS states that "teenagers must be able to tolerate the discomfort and temporary disfigurement of a surgical procedure."[40] Even so, the risks of surgery (while elective) are weighed against a backdrop similar to that of a patient seeking gender affirming care, as both surgeries impact how the patient is perceived to the outside world, and how they see themselves. Cosmetic surgery can have a positive impact on one's personal identity and may relieve insecurities that negatively impact the patient's overall quality of life.[40] Much like the transgendered community, not all of the population find breast augmentation or rhinoplasty to benefit their overall quality of life, but for those who do deem it necessary, it can have positive impacts such as the reversal of social withdrawal, improvement in self-esteem, and a reduction in physical, social, and psychological burdens related to appearance satisfaction.[40,41] The rules and regulations put in place by the ASPS state that adolescent patients <18 years old and their care team are deemed fit to

participate in shared decision-making for irreversible surgical decisions (i.e., cosmetic surgery), but this is not the case for a TGNC adolescent patient seeking gender affirming surgery.

D. Disorders of Sex Development and the Intersex Population

Every day, children in America are born with disorders of sex development (DSD). DSDs are defined as "congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical."[42] A patient with a DSD may experience any type of condition in which sex develops differently from what is medically considered typical development. The Accord Alliance is a non-profit project dedicated to educating the public and medical professionals on integrated health care approaches for people and families affected by DSDs.[43] Additionally, the Accord Alliance stipulates that people affected by DSDs are not considered Transgender, as DSD and their treatment focus on physical sex development and not gender identity.[42,43]

Children born with a DSD experience much of the same medical complexities and face the same serious medical decisions as the TGNC patient with regard to genital surgeries. For example, both populations rely heavily on input from a multidisciplinary team of physicians. Unlike TGNC youth who yearn for their autonomous decisions to be respected, children with DSD have historically experienced a different ethical injustice of autonomy as surgeries for DSD were performed before the child was old enough to even express an opinion.

Historically, children with DSD (previously called "intersex") were treated to eliminate the ambiguity of the genitals to align with a "normal" gender identity.[44] However, the "optimum gender of rearing" model was more or less created on the belief that since "it was harder to surgically engineer a boy than a girl, most children with intersex were made as feminine as possible, utilizing surgery, endocrinology, and psychology. A 'successful' patient was one

judged to be stable and 'normal' (i.e., heterosexual) in the assigned gender."[44] This type of reassignment surgery continued until the 1960's but remained a stigmatizing and shameful practice for both the parents and the child.[44,45]

Even today, interACT (Advocates for Intersex Youth) has partnered with the Human Rights Watch to continue to demand reform to the current practice of unnecessary surgical procedures being performed on children with DSD. They argue that "the lack of standards limiting the discretion of doctors to recommend and conduct medically unnecessary surgeries represents a failure of the government as well as medical governance bodies to live up to human rights standards" and warn against the detrimental effects of current practices, saying "the experience of those who have undergone the surgery and principles of medical ethics suggest that unless and until there is outcome data establishing that the medical benefits of specific surgical procedures on infants and young children outweigh the potential harms, they should not be used."[45]Therefore, the idea of performing genital surgery on children before they can assent is troubling, and the pursuit of the DSD community to ban these procedures before child assent is an important one.

The main takeaway from the analogy of genital surgery for the treatment of DSD is not the act of genital surgery itself, but the current rules and culture surrounding the procedure. Unlike TGNC patients seeking irreversible genital affirming surgery, adolescent patients under the age of 18 with DSD are allowed (and encouraged) to participate in shared decision-making regarding irreversible genital surgery. However, current medical practice promotes that parents of minor children with DSD can decide on irreversible genital surgery for their child, even without the child's assent. In the case of the current DSD procedures, there is not a distrust in parental decision making (as exists with TGNC adolescent patients), but an unhealthy emphasis on it.

The AAP endorses the promotion of shared decision-making for DSD patients between the physicians and their families in its statement on DSD, stating "The American Academy of Pediatrics agrees it is important that a child's medical team and parents engage in open, transparent conversations so that parents fully understand their child's condition and the risks and benefits of any proposed treatment, as well as alternatives, such as delaying surgery."[46] The same respect and decisional latitude given to DSD patients and their families to make decisions about a genital surgery being in the best interest of the child should *also* be given to TGNC adolescent patients and families. The lesson to be learned through this example is that children and adolescents facing these health risks should remain a part of the discussion, and guidelines should be developed to fit the needs of each individual TGNC patient as is advocated for DSD patients, even if that patient is under the age of 18.

E. Bariatric Surgery

Bariatric surgery is a surgical procedure used to treat obesity and associated comorbidities in adults, adolescents, and children. The impacts of obesity may appear to be physical, such as the development of Type 2 diabetes mellitus, obstructive sleep apnea, non-alcoholic fatty liver disease, or cardiovascular disease, but can also present as psychosocial challenges that impact mental health.[47] Psychosocial comorbidities are especially common among obese children and adolescents who find themselves the victims of bullying from an early age. Some psychosocial comorbidities related to childhood obesity are similar to that of the transgender population, such as depression and negative impacts on quality of life.[7,47] The time sensitivity of bariatric surgical intervention varies by patient and is determined as part of the bariatric team evaluation, just as it is determined by the professional team providing gender affirming care. The American Society

of Metabolic and Bariatric Surgery (ASMBS) states that the goal of bariatric surgery in all people including adolescents is to "provide the most benefit possible with the lowest risk."[47] The types of bariatric surgery available are Gastric Bypass, Laparoscopic Adjustable Gastric Band (LAGB), Vertical Sleeve Gastrectomy, as well as Biliopancreatic Diversion and Duodenal Switch which are less common in pediatric patients.[48] Most bariatric surgeries are considered irreversible and come with risks patients and parents must weigh against proposed benefits. Potential risks outlined by the ASMBS include life-threatening surgical complications, the development of negative psychosocial conditions, and the occurrence of nutritional deficiencies, namely low levels of iron, vitamin B12, vitamin D and calcium necessary for proper bone development.[47]

Whether an adolescent meets the criteria for bariatric surgery is determined by a multidisciplinary team of professionals, such as the bariatric surgeon, pediatric specialist, and mental health specialist. In describing the process of determining a patient's candidacy for surgery, ASMBS states that the bariatric team should evaluate the BMI of the adolescent, and consider comorbidities and potential long-term health risks of untreated obesity.[47] Although the use of a multidisciplinary team is also part of the process for patients seeking gender affirming care, there is one important difference. Unlike adolescent patients seeking gender affirming care, adolescent patients seeking bariatric surgery are allowed to engage in the informed consent process with their parents and physicians to determine if bariatric surgery is in their best interest. Additionally, if bariatric surgery is deemed appropriate for the specific adolescent patient and is both consented to by the legal guardians and assented to by the patient, the patient can receive the treatment before the age of 18.

There is one specific type of bariatric surgery that, even if it is requested jointly by physician, patient and parents, is denied if the patient is under the age of 18.[47] ASMBS warns that adolescents who meet the criterion for LAGB but are under 18 are unable to participate in the surgery because the adjustable gastric band used in the procedure has yet to be approved by the FDA. While this is an example of another medical surgery that is prohibited before age 18, even with appropriate consent and assent, there is one notable difference. Even though bariatric patients may have barriers to receiving LAGB before age 18, there are alternative options available to achieve similar effect. Patients can either receive LAGB through the use of an "off-label" banding device or can undergo a different type of bariatric surgery.[47] When TGNC adolescent patients are denied genital surgery before age 18, they do not have any alternative options available. The ability for adolescent patients to receive bariatric surgery, despite its irreversibility and risks perpetuates the idea that this irreversible surgery has some societally given "value" that TGNC irreversible surgeries do not have.

In conclusion, the situation of bariatric surgery in adolescent patients has similarities to those seeking gender affirming care, such as psychosocial comorbidities, and for some, experiencing an age restriction until the age of 18 for patients seeking LAGB. However, bariatric patients under the age of majority still have access to other types of bariatric surgery. The main takeaway of the comparison of bariatric adolescent patients and TGNC adolescent patients is that both genital surgery and most types of bariatric surgery are considered irreversible treatments with serious implications for psychosocial comorbidities, and both employ a complex patient candidacy process evaluated by multidisciplinary teams. However, bariatric adolescent patients are encouraged to utilize fully informed consent and shared decision-making with their families

and multidisciplinary physicians, a luxury not afforded to patients <18 years old seeking gender affirming care.

F. Conclusion

As shown, the medical community routinely supports and performs medically important (or not important), and at times irreversible, treatment on minors for a variety of health reasons and outcomes. The above examples emphasize the value the medical community places on shared decision-making to promote the best interest of the child during these procedures and treatments. It is clear that the age requirement prohibits autonomous choice for TGNC minor patients, physicians, and families as it robs them of the ability to explore, weigh risks, and consent/assent to care that is in the youth's best interest. The fact that shared decision-making dictates medical decisions routinely for adolescent patients, yet the age requirement blocks any shared decision made in favor of genital surgery for a TGNC minor, reveals a systematic mistrust targeting TGNC youth and their ability to make decisions with their parents and multi-disciplinary team. Therefore, the age requirement present in the SOC imposes a predetermined discriminatory view that TGNC patients as well as their parents/guardians and physicians are unfit to determine if performing an evidence-based treatment for a medically complex health issue in in the patient's best interest prior to their 18th birthday.

III. Addressing "Regret"

While not specifically addressed in the WPATH SOC, it is widely assumed that the age requirement for genital surgery is put in place to protect youth from making a decision they will

"regret." This is a vague sentiment that continues to express doubt in TGNC youth and their capacity to properly engage in shared decision-making with medical professionals. Even so, regret remains a salient concern in the medical ethics literature. Commonly discussed topics include the regret of transitioning, loss of fertility, reduced sexual pleasure and the medical risks of the procedure itself. The frequency of this objection begs the question: what is so different and so special about genital surgery for TGNC youth that we bar patients from accessing medically proven evidence-based practices?

A. Regretting Genital Surgery

The WPATH SOC authors understand that the nuances of gender affirming treatments provoke skepticism in both the general public and medical community. To address these common reservations, WPATH included Appendix D "Evidence for Clinical Outcomes of Therapeutic Approaches" in its SOC.[6] In Appendix D, WPATH reviews both historic and current clinical studies surrounding the outcomes of both surgical and therapeutic approaches for TGNC patients. It is in Appendix D where WPATH outlines the results and limitations of the most influential retrospective studies on reassignment surgery. According to WPATH SOC, none of the patients involved in the Rehman et al. (1999) and Krege et al. (2001) studies regretted having surgery.[6,49,50] WPATH references the largest prospective study by Smith, Van Goozen, Kuiper & Cohen-Kettis, (2005) which concluded that both adult and adolescent patients who underwent sex reassignment therapy (both hormonal and surgical intervention) "showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories with fewer than 2% of patients expressing regret after therapy."[6,51] Another study from Sweden found that

"almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning."[6,52]

More recent regret study results also promote the use of gender affirming treatments. The 2018 Amsterdam Cohort of Gender Dysphoria Study (1972-2015) of 6,793 people found that only 0.6% of transwomen and 0.3% of transmen who underwent gonadectomy were identified as experiencing regret, and further concluded that "the number of people with gender identity issues seeking professional help increased dramatically in recent decades. Yet, the percentage of people who regretted gonadectomy remained small and did not show a tendency to increase."[53] A smaller study of 254 consecutive patients undergoing male-to-female gender reassignment surgery from Germany also found gender reassignment surgery to have high satisfaction rates and to be beneficial overall.[54] Additionally, an Iranian study focusing on the quality of life of patients undergoing male-to-female reassignment surgery found that patients suffering from GD "have a low quality of life before surgery that is significantly improved 6 months after surgery and in all domains,"[55] including the domains of 'total physical health' and 'total psychological health'.[55]

Further, sexual health and sensitivity appear promising for patients. While anorgasmia (the inability to orgasm) is stated as a potential complication in the WPATH SOC, this seems to be of little concern based on published data.[6] A retrospective 2005 Dutch study found that 100% of transgender men and 85% of transgender women were able to orgasm after receiving genital surgery.[56] By contrast, the 2009 National Survey of Sexual Health and Behavior (NSSHB) found that for adults ages 18-59, only 91% of men and 64% of women reached climax during their last sexual encounters.[57] Several studies have found that the number of ciswomen (women whose

gender identity matched with the sex they were assigned at birth) who suffer from anorgasmia is not much lower than transwomen.[58]

The results appear promising for patients seeking gender affirming genital surgery but more research on risk of regret is needed for adolescent patients. Unfortunately, a common shortcoming of medical research is the difficulty to include minors in research, leaving a literature gap that negatively influences the treatment of patients. Meanwhile, the age requirement restricts any chance of more focused and conclusive research on adolescent regret, as adolescents are not permitted to have this surgery in the US.

B. Effects on Fertility

Another potential defense of the age requirement is the concern about infertility after genital surgery. It preys on the common patient concern of the effects gender affirming treatments may have on fertility and the patient's ability to have children in the future. The importance of addressing fertility questions, concerns and preferences with TGNC patients of all ages are addressed in Chapter IX Reproductive Health of the WPATH SOC.[6] WPATH acknowledges the importance fertility may hold for any patient, and as such named it the second task in Chapter VII, under the "Responsibilities of Hormone-Prescribing Physicians."[6] Here, WPATH mandates clinicians and providers to utilize the shared decision-making model early on in the stages of transition, as feminizing / masculinizing hormone therapy can cause a reduction in fertility.[6,59] One study referenced by WPATH found there were some cases of patients later regretting not being able to have genetically related children due to hormone therapy.[6,60] According to the same 2002 study "more than 90% of the respondents stated that loss of fertility was not an important

reason to delay their transition. The rest were still wrestling with the problem of losing their fertility and a few wanted to wait with all forms of treatment until they had children."[6,60]

Regardless of age or initial interest, the SOC state "these discussions should occur even if patients are not interested in [discussing issues surrounding fertility] at the time of treatment, which may be more common for younger patients."[61] Additionally, the WPATH SOC include current reproductive options for both Male-to-Female patients such as sperm freezing, and Female-to-Male patients such as oocyte (egg) or embryo freezing.[6] A recent study found that the utilization of fertility preservation strategies in transgender adolescents (aged 14.2 to 20.6) is low, and identifies barriers to utilization such as cost, invasiveness of procedures, and desire not to delay medical transition.[61] However, these are conversations and considerations that are needed early on in the stages of treatment, well before final consideration of genital surgery. Patients at the stage of pursuing genital surgery have been following the SOC timeline which requires prolonged months of interactions with their treating physicians and care team, resulting in extended time to think about, discuss, and reconsider their fertility preferences. Additionally, new biotechnical advances in Assisted Reproduction Technology (ART), in vitro fertilization (IVF), and surrogacy provide transgender persons more opportunity to parent a genetically related child.[62]

For TGNC adolescent patients the ethical concern does not lie with the potential for regret, but with the lack of emphasis on shared decision-making. "For all patients, shared decision-making strategies that facilitate dialogue between families, providers, and patients while taking into account the patient's level of maturity and individual decision-making capacity have been shown to facilitate informed consent and decisions in the best interest of the patient."[63,64] A 2017 Case Illustration on Fertility Counseling for Transgender Adolescents and Young Adults

concluded that there is a severe need for shared decision-making in this space. “Transgender adolescents choosing to transition to their affirmed gender need health care providers who are committed to assessing and supporting their short term and long-term desires.”[64] Other ethical considerations raised by Chen and Simmons (2019) include the idea that “compromising future fertility may be an acceptable risk in the context of immediate relief from dysphoria” as well as the imperative need for “transgender healthcare providers, particularly those who see adolescents, to be knowledgeable and comfortable discussing complex issues related to fertility and reproductive health.”[61]

Therefore, what remains is not the concern of infertility in relation to genital surgery, but the idea that TGNC adolescents cannot adequately predict their future reproductive wants and needs. As more adolescents seek gender affirming care and clinical research evolves on the fertility effects of transitional treatment, the field of bioethics continues to delve into the ethical considerations of fertility preservation in transgender youth. WPATH supports the ability to preserve fertility in transgender persons, as the elaborate timeline allows for flexibility in fertility decision-making and the support of artificial reproductive technology (ART) options in early treatment. Only shared decision-making with knowledgeable providers utilizing comprehensive fertility counseling can assure quality assessment of long-term fertility preferences. The age requirement itself does not provide any additional reassurance about the decision of fertility preservation in youths. The installation of the age requirement does however reiterate a systematic mistrust that TGNC youth are incapable of working with medical professionals and families to determine their “final” fertility preferences until their 18th birthday.

IV. Current Protections

The removal of the age requirement may appear to be an added protection for minors in the SOC. However, there are other powerful protections currently in place that would protect patients' best interest without the age requirement. As a reminder, the patients discussed in the context are presumed to have stable parental support and consent, as well as cohesive physician consent and financial ability to support the treatment. Criteria II in the WPATH SOC for "Irreversible Interventions" states that a patient must live in their desired gender role for at least 12 months.[6] This assures that the patient is comfortable and well-adjusted to the gender congruent with their gender identity well before they become eligible for irreversible interventions.[6] For some patients, this one-year mark may place them as ineligible until after their 18th birthday, in which case the age requirement becomes an irrelevant barrier.

Further, the WPATH SOC suggest a staged process for transitioning of adolescents. This staged process of fully reversible interventions (such as social transitioning and puberty blockers) before partially reversible interventions (hormone therapy) is intended to offer flexibility and provide a variety of options for patients and their families. WPATH SOC also address the importance of these stages, stating "moving from one stage to another should not occur until there has been adequate time for adolescents and their parents to assimilate fully the effects of earlier interventions."[6]

Additionally, gender centers across America are adapting and refining their own requirements to protect the patient's best interest. For example, The Philadelphia Center for Transgender Surgery utilized the WPATH SOC for individualized treatments, but also requires that "surgery is recommended by two mental health specialists trained in gender identity issues."[65] The additional requirement of two letters of support from mental health professionals

trained specifically in gender care appears to be common among surgical institutions. The two letters of support may include documentation of persistent well-documented GD, psychosocial assessment, patient's decision-making capacity for fully informed consent and emotional and mental well-being. These additional requirements are also found in some insurance plans, such as Aetna[32].

It is easy to assume that the age requirement places an added protection for patients to make fully informed decisions. However, the true protections for the patient's best interest lies within the SOC already. The multi-staged treatment process, extensive inclusion of gender care physicians, psychiatric professionals, and thorough informed consent of both the patient and their parents ensure that the patient's best interest remains at the center of their care. The removal of the age requirement would still allow patients seeking treatment to work with their team to optimize the benefits and limit any negative outcomes of treatment, without discriminating against an extremely vulnerable and at-risk population.

As with any major surgery, adolescents are faced with difficult decisions that will affect their lives in the future. Concerns about adolescent decision-making capacities for long-term decisions such as future fertility and sexual health remain in the context of adolescent gender affirming care. Ironically, sexual and reproductive health are one of the few areas where adolescents are routinely given the authority to consent on their own. TGNC adolescents should not be assumed to be incapable of making these decisions any more so than a cis patient. Serious long-term effects of surgery should be considered and re-evaluated by the patient, their family and medical professionals over time just as they would be for any other adolescent expected to undergo a major surgery before the age of 18. The current medical literature supports the beneficial outcomes of the evidence-based practice of genital surgery for TGNC persons. The call for more

education of medical professionals on how to best utilize shared decision-making in gender affirming care remains salient, as does proper capacity evaluation of patients and comprehensive counseling regarding fertility options. The age requirement itself does not realistically influence the long-term decisions made by patients and their care team and serves no purpose but to barricade youth from effective health care.

V. Proposed Solutions

The remedy for this discriminatory barrier to care is a relatively straight forward one that already exists within the writings of the WPATH SOC. The proposed solution is simple. Step 1 is **to remove the age requirement** from the Genital Surgery section of WPATH SOC. Step 2 is to remove the phrase "**minimum criterion**" in the sentence "The age threshold should be seen as **a minimum criterion** and not an indication in and of itself for active intervention."[6] Step 3 is to implement the language that is already present in the WPATH SOC for Chest Surgery: "preferably after ample time of living in the desired gender role, **agreed upon by physicians, family, and therapists."**[6] Through these adjustments, the WPATH SOC criteria for Genital Surgery for adolescents would read, "Genital surgery should not be carried out until patients have lived continuously for at least 12 months in the gender congruent with their gender identity. Genital surgery should only be carried out after ample time of living in the desired gender role, and is agreed upon by physicians, family and therapists." Finally, a call for more utilization of true shared decision-making and further research on effectiveness/outcomes in adolescents is needed.

VI. Conclusion

WPATH remains a positive leader in transgender and gender nonconforming health care relied heavily upon by many physicians, institutions, insurances, patients and families. It is because of the prestige and prominence WPATH holds that one should re-evaluate the discriminatory impact the minimal age criterion has on adolescents seeking gender affirming care. Exemplified above, the risks of withholding treatment remain high for these adolescents and their families. GD and the associated comorbidities such as mental health issues, stigmatization, discrimination, self-inflicted harm, homelessness and violence present serious negative health outcomes for these marginalized patients.[2,3,4] The costs these patients bear is serious and complex. Not providing TGNC patients, their families and their medical team with full autonomy in making decisions based on the patient's best interests is against the suggested guidelines of the AMA Code of Medical Ethics. It also goes against the WPATH Risks of Withholding Treatment, as the age requirement in place as the minimum criteria for genital surgery prohibits patients and families from accurately weighing the risks of inaction against the benefits of treatment.

The age requirement continues to masquerade as a protection for these youth when really it is a barrier to health care, perpetuating societal biases that TGNC youth, their families, and physicians are incapable of possessing the true autonomous capacity for decision-making that non-TGNC youth and their families are routinely afforded for most other medical decisions. Through examination of other medical standards of practice for non-TGNC youth, it is clear that the age requirement for genital surgery is unique to TGNC youth. So, what is driving these special protections? At best it is an honest yet misguided desire to protect a vulnerable population. At worst it is a mistrust of and discrimination against TGNC youth and their

supportive families. The implementation of the proposed solutions would simply give TGNC youth and their families the ability to participate in shared decision-making with their trusted physicians to determine what is in the best interest of the child. The removal of the age requirement is not to say that all TGNC patients should automatically include irreversible genital surgery in their treatment, nor would it bypass parental consent and professional medical advice. The elimination of the age restriction would merely afford TGNC the same opportunity as other adolescents to make personal medical decisions after weighing risks and benefits through a process of shared decision-making. Trans rights are human rights, and our leading providers in health care must continue to make strides for ALL patients within the human right of health care.

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